AGENDA
ORGANIZATIONAL MEETING
OF
ALABAMA OPIOID OVERDOSE
AND ADDICTION COUNCIL

September 5, 2017
1:00 pm

I. WELCOMING REMARKS

II. INTRODUCTIONS

III. OVERVIEW OF TASK FORCE

IV. COMMITTEE REPORTS

V. ANNE M. SCHMIDT, MD, MEDICAL DIRECTOR
BLUE CROSS AND BLUE SHIELD OF ALABAMA
"WHAT'S THE COST? A BLUE CROSS PERSPECTIVE"

VI. ALAN MILLER, DIRECTOR OF COMPACT 20/20 &
SHELBY COUNTY CHIEF ASSISTANT DISTRICT ATTORNEY
"AN OVERVIEW OF COMPACT 20/20"

VII. ANNOUNCEMENTS & CLOSING REMARKS

Alabama Opioid Overdose and Addiction Council - Council Members/Attendees 9/5/17

Council Members	
Name	**Agency/Organization**
Albright, Dr. David	University of Alabama
Alverson, Dr. Susan	AL Board of Pharmacy
Babington, Bill	ADECA
Beasley, Billy	State Senator
Beech, Elaine	State Representative
Beshear, Lynn	Mental Health
Butler, Dr. Erica	AL Dept. of Education
Butler, Paul	Dept. of Human Resources
Cook, Foster	Jefferson Co. Pills to Needles
Dunn, Jefferson	Dept. of Corrections
Frick, Myra	Dept. of Insurance
Green, Norris	Medical Examiners
Harris, Dr. Scott	Public Health
Hart, Matt	AL Board of Dental Examiners
Helms, Randy	Administrative Office of Courts
Herrick, Dr. David P.	Medical Association
Johnson, Deidre	Council on Substance Abuse
Johnson, Josh	WSFA
Jones, Louise F.	AL Pharmacy Association
Litvine, Mark	Recovery Organization of Support Specialists
Marshall, Steve	Attorney General
Matson, Barry	AL Drug Abuse Task Force
McClendon, Jim	State Senator
McVeigh, Brian	DA's Association
Moon, Dr. Robert	Medicaid
Morgan, Darrell	Pardons and Paroles
Partlow, Pearl	Council on Substance Abuse
Schmidt, Dr. Anne M.	Blue Cross Blue Shield
Slattery, Ann	AL Regional Poison Control Center
Staats-Combs, Susan	AL Methadone Treatment Assoc.
Studstill, Dr. Zack	AL Dental Association
Taylor, Bobbi Jo	Recovery Organization of Support Specialists
Taylor, Hal	ALEA
Taylor, Dr. Stephen	AL Society of Addiction Medicine (Boyett)
Traffanstedt, Dr. Darlene	Internal Medicine Physician
Weaver, April	State Representative

Non-Council Members/Staff	
Name	**Agency/Organization**
Baugher, Diane	Mental Health
Boswell, Kim	Mental Health
Crenshaw, Clay	AGO
Crumpton, Ashley	COMPACT 2020
Duddy, Thomas	AdaptPharma
Durham, Jamey	Public Health
Hardin, Brian	ALFA
Harkless, Sarah	Mental Health
Jones, Dr. Tony	UAB Medicine
Klinner, Tommy	Mental Health
Miller, Alan	COMPACT 2020
Stone, Robin	Blue Cross Blue Shield
Walden, Nicole	Mental Health
White, Dave	Governor's Office
Wiggins, Gene	ALEA

Alabama Opioid Overdose and Addiction Council
Executive Order No. 708
Membership as of 9/5/17

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b) State Health Officer
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c) State Attorney General
Steve Marshall
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d) Chair of the Alabama Board of Medical Examiners
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e) Physician appointed by the Medical Association of the State of Alabama (designee)
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f) Executive Secretary of the Alabama Board of Pharmacy
Dr. Susan Alverson, Pharm. D.
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g) Executive Director of the Alabama Pharmacy Association
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t) Chairman of the Alabama Drug Abuse Task Force
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u) President of the Alabama Methadone Treatment Association
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v) Representative of the Jefferson County Pills to Needles Collaborative
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w) President of the Alabama District Attorneys' Association
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x) Two House members appointed by the Speaker of the Alabama House of Representatives
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April Weaver, State Representative
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y) Two Senators appointed by the President Pro Tem Of the Alabama Senate
Billy Beasley, State Senator
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Jim McClendon, State Senator
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z) Two individuals, in recovery from opioid addiction, appointed by the Recovery Organization of Support Specialists
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Bobbi Jo Taylor
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aa) Two family members, of persons who are or have been addicted to opioids, appointed by the Council on Substance Abuse – NCADD
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bb) Additional individuals as deemed appropriate by the Governor

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Dr. Brent Boyett, DO
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Boyett Health Services, Hamilton, AL
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Josh Johnson
Chief Meteorologist at WSFA television in Montgomery.
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Dr. Anne M. Schmidt, MD
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MEMORANDUM

TO: Steve Marshall, Attorney General
FROM: Eric Palmer, Assistant Solicitor General
DATE: August 22, 2017
RE: State Responses to Opioid Epidemic

This memorandum summarizes the policy recommendations developed by the States to combat the opioid epidemic. I found that there is a broad consensus among the states regarding appropriate strategy for combatting the opioid epidemic. Noteworthy reports were authored by Georgia, Massachusetts, New Hampshire, and Utah, which I have marked for your consideration.

Please let me know if you have any questions regarding this memorandum, or if you would like any information regarding the data or other evidence supporting each of the policy recommendations outlined below.

I. Environmental and Social Determinants of Health

The consensus is that an effective response to the opioid epidemic requires systematic and sustained measures to reduce and control access to opioids, promote the use of alternatives to narcotic pain management, and reform professional and regulatory standards to eliminate prescription practices that may increase the incidence of addiction.

Reducing and Controlling Access to Opioids

- Communities statewide should provide timely and convenient access to **medication take-back and disposal programs** to prevent medication use by individuals for whom the prescriptions were not written.
- State **prescription drug monitoring program (PDMP)** should improve ease of use and incentivize participation by prescribers. Require participation by health care providers, including physicians, pharmacists, dentists, orthopedists, and other professionals who prescribe opioids.
    - State should comply with CDC guidelines, which instruct prescribing physicians to check the PDMP database at least once every 3 months and prior to writing every opioid prescription.
    - Require all providers to check the PDMP before prescribing Schedule II, III, and IV controlled substances. Require providers to report to the PDMP within 24 hours.
    - Authorize sharing of PDMP information across state lines. Integrate PDMP data into physician and hospital electronic health record systems.
    - Develop guidance to use information from State PDMPs to refer prescribers to licensing authorities or law enforcement when prescription patters raise objective concerns about violation of criminal statutes or medical standards
    - Law enforcement should have the ability to upload information regarding inappropriate use of scheduled drugs into the PDMP
    - Professional guidelines should instruct providers to never fire patients based on information regarding their use of opioids.

- Implement state enhancements to the Controlled Substance Utilization Review and Evaluation System (CURES), DOJ's prescription drug monitoring system.
    - Pharmacies must submit data on all dispensed controlled substances within seven days of issue. Under CA law, prescribers are required to check CURES before writing new prescriptions, and then every four months thereafter.
- Some states proposed additional federal-state collaboration to prevent illegal importation of opioids and/or enhanced penalties for opioid trafficking, as well as increased oversight of "pill mills."
    - Alabama is one of the states which already has a pain clinic law. Effectiveness of the law should be monitored in accordance with recommendations like those made in GA's report.
    - Require individuals to show proper identification when picking up schedule II or III narcotics prescriptions in order to prevent prescription fraud and diversion.
- The State should support ongoing data collection and analysis of the opioid epidemic, working with community hospitals and universities when appropriate.
    - Create more addiction medicine research fellowships at state universities
    - State public health officials conduct population-level analysis to assess trends in prescriptions statewide and locally

Reducing Risk of Opioid Misuse, Abuse, and Dependence

- Promote **alternatives to narcotic pain management** by reforming medical guidelines to encourage alternative treatments and requiring reimbursement for such treatments by public and private health plans.
    - Non-pharmacologic therapies and non-opioid medications are effective options for managing pain in many cases. Improving access to alternative therapies ensures that opioid pain medications will be reserved for the most acute pain.
- **Regulations and/or professional guidelines** governing opioid prescriptions should be reformed to reduce the risk of addiction.
    - Effective guidelines should require real informed consent, careful consideration of new starts on long-term opioid treatment, and call for low doses and short prescription durations.
    - A comprehensive evaluation should be performed before initiating opioid treatment for chronic pain. Opioid medications should be prescribed only after determining that non-opioid medications or therapies will not provide adequate pain relief.
    - Regulations and/or guidelines should restrict or eliminate automatic renewals of narcotic prescriptions
    - Amend professional guidelines to adopt a morphine equivalent dose limit of 90 mg/day (Alaska, Washington), except in rare and exceptional circumstances.
    - Reduce prescription limits for opioids to 7-10 days, excepting chronic pain and other specified conditions.
    - Guidelines should be harmonized across professions (dentists and orthopedists)
- Implement programs to **promote public awareness** about safe use, safe storage, and safe disposal of prescription medication, as well as treatments for substance abuse disorder, including opioid agonist treatments (e.g. naloxone).
    - Combat public impression that prescription drugs are safer than street drugs.

- Primary prevention of substance use disorders through faith-based programs, school-based programs, and community coalitions that offer education and resiliency training should target geographic areas that experience high rates of opioid overdose

II. Chronic Disease Screening, Treatment, and Management

Patients should have access to outpatient treatment, intensive outpatient treatment, residential treatment, detoxification, medications, and recovery support services. Because opioid withdrawal is not generally considered life threatening, detoxification is generally not covered by Medicaid and private insurance, making access to inpatient or outpatient opioid detoxification services extremely limited. Integrating treatment into existing systems of care is the chief priority.

Integrating Opioid Use Disorder (OUD) Treatment into Systems of Care

Public and private health payers should support the integration of OUD treatment into primary care and reimburse the cost of medications used for medication-assisted treatment (MAT).

- End prior insurance authorization and allow for immediate access to inpatient treatment for OUD/access to medication to manage withdrawal symptoms. So long as an individual and his/her health service provider say it is needed, treatment should be available.
  - GA law would allow insurers to conduct utilization review after 14 days of treatment.
- State law should require all insurance companies to use objective state-approved criteria to determine the level of care for individuals suffering from OUD.
- Public and private health plans should promote and reimburse screening, brief intervention, and referral to treatment (SBIRT) in all health care settings.
- Payers should contract with adequate networks of community-based behavioral health providers to improve access to community-based care. Public and private health plans should provide parity for inpatient and residential substance use disorder treatment.
- Payers should support initiation of opioid use disorder treatment in acute care settings in coordination with accountable, integrated systems that allow for timely access to follow-up care, and facilitate collaboration between providers of different levels of care to minimize loss to follow-up during transitions between settings.

Screening and Referral

- Public and private health providers should reimburse clinical assessments of risk of abuse and overdose whenever opioids are prescribed
- Mental Health First Aid and Crisis Intervention training should be integrated into all state and local law enforcement and public safety officer academy curriculums.
- Aging and disability resource centers, care coordination providers, and other referral resources should provide up-to-date information about local behavioral health treatment services to health care providers.
- Pain management specialists should have information/tools, and be reimbursed, for screening patients for depression and other mental health disorders that may be contributing to or exacerbating conditions causing pain, and providing "warm hand-off" referrals of patients to appropriate mental health treatment

Treating OUD

- Focus on **effective pharmacological treatments**, substituting **buprenorphine treatment** for methadone and naltrexone.
    - Unlike methadone, buprenorphine can be used in office-based settings and outpatient treatment programs. Research indicates that buprenorphine is associated with fewer withdrawal symptoms, lower risk of misuse and overdose, and increased treatment retention.
- Implement a **comprehensive withdrawal management/detoxification system** in a variety of health care settings, specifically including rural and correctional health care settings
- Adopt innovative **neonatal abstinence syndrome (NAS)** treatment models. Although use of pharmacologic treatment (e.g. buprenorphine) to treat OUD during pregnancy can result in NAS, the American College of Obstetricians and Gynecologists recommends *against* tapering pregnant women off pharmacologic treatment because of the associated risk of addiction relapse, which poses a greater risk to fetal and early childhood development.
    - Introduce use of non-pharmacologic interventions including low-stimulation rooms, swaddling, feeding on demand, etc. to treat NAS.
    - Utilize verbal screening for pregnancy intention and offer pregnancy testing to women undergoing MAT or other treatment for substance use disorder
    - Screen pregnant women and refer them to brief intervention and/or referral to treatment (SBIRT) if they test positive
        - Law enforcement responses are generally inappropriate and discourage use of treatment. Screening and toxicological testing should not occur without informed consent.
    - Public health campaign to educate the public about NAS and birth defects associated with use of opioids during pregnancy
- Medical professional organizations should develop and/or deliver education to train and support health care providers in implementing the state prescribing guidelines.
    - All state licensed, registered, and certified health care professionals should complete addiction medicine continuing education hours prior to each license renewal. State and health care organizations should partner to make continuing education free or low-cost.
    - As was done with HIV treatment, make preventing and treating OUD and substance use disorder should be part of the core curriculum for primary care in medical schools and residency.
- Explore telemedicine programs as a way of reaching underserved communities, create a statewide addiction hotline, and an online database of treatment facilities to enable expeditious referral of patients for MAT.
- Expand access to drug courts and therapeutic justice alternatives, which may reduce recidivism by connecting criminal defendants with appropriate treatment and social supports in a structured environment of accountability.
- Promote use of broad-based, multi-stakeholder coalitions between community hospitals, outpatient providers, patients and their families, and other key stakeholders to address the epidemic locally. Enhance access to state-level rapid response assistance to spikes in local overdoses.

- WV proposed a state-wide investigation system to monitor incidence of nonfatal opioid abuse to enable timely allocation of state resources to aid local authorities in overdose outbreaks. A similar system has already been implemented by Ohio.

Recovery Services

- Public and private health plans should reimburse and support providers to offer **peer recovery mutual support**. State should support expansion of existing recovery networks to include individuals suffering from OUD, including those receiving MAT
  - Require hospitals to provide follow-up treatment and recovery support options to individuals upon hospital discharge
  - Expand peer-based recovery networks to support long-term recovery. Services should also include linkages to education and employment resources, legal services, social services, transportation assistance, childcare services, and peer support groups.
  - Ensure access to 12-step and other group recovery programs for incarcerated individuals and in the juvenile justice system
- Local and state authorities should incentivize, educate, and support **"second chance"** employers (i.e. employers willing to hire people in recovery from OUD and other substance use disorders).
  - Expand services for individuals in recovery who are re-entering the community rom incarceration and residential substance use disorder treatment, to include supportive and transitional housing services.

III. Harm Reduction

The primary methods of harm reduction considered by the states focus on overdose prevention and reducing morbidity from overdoses. Present overdose prevention strategies can be enhanced by the implementation and/or expansion of monitoring systems to detect at-risk patients. Measures to reduce co-prescription of drugs known to increase the risk of accidental overdose, such as benzodiazepine, are important. The chief method of addressing morbidity is expansion of access to affordable naloxone.

Overdose Prevention

- Health care providers and payers should develop **effective monitoring systems** to identify and intervene with high-risk prescriptions (frequent refills, large dosages, etc.)
  - Cedars-Sinai built electronic decision supports, such as alerts and standard templates, into its EPIC health record, allowing risk stratification of patients and referrals to multimodal treatments
  - Insurers and providers can implement systems to complement PDMPs, providing tools for health care providers and pharmacists to identify when patients are at risk due to high-dosage or high-volume opioid prescriptions.
- Decrease **opioid and benzodiazepine (e.g. Xanax) co-prescribing**, which increases the risk of overdose. Prohibit prescription of opioids and/or benzodiazepines without a PDMP check, alter prescribing guidelines, and ensure that patients are informed of the risk of using opioids in conjunction with benzodiazepines

Reducing Morbidity

- **Access to affordable naloxone** is essential to reducing morbidity from overdoses and the number of hospital admissions caused by prescription overdose.
    - Public and private health plans should reimburse cost-effective naloxone preparations.
    - Prescriptions and training for naloxone should accompany all prescriptions exceeding 90mg/day morphine equivalent dose
    - All first responders (EMTs, firefighters, police, etc.) should be trained and equipped with naloxone. The National School Nurses Association made a similar proposal for schools, and Adapt Pharma is offering naloxone to schools around the country free of charge.
    - Education on administration of naloxone should be included in basic CPR and First Aid Training curricula
- Criminal statutes and law enforcement policies **should not discourage reporting of overdoses**. Alabama could adopt a **Good Samaritan Law** protecting victims and witnesses from arrest or prosecution for possession or use of illegal drugs when, in good faith, they seek emergency medical assistance for themselves or others in an opioid overdose situation.

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ANGIE FIESE, DIRECTOR
ALEX AZARIAN, DEPUTY DIRECTOR
ELIZABETH HOLCOMB, PROJECTS MANAGER

FINAL REPORT OF THE OPIOID ABUSE SENATE STUDY COMMITTEE

COMMITTEE MEMBERS

Senator Renee Unterman – Chair
District 45

Senator Butch Miller
District 49

Commissioner Brenda Fitzgerald, MD
Department of Public Health

Rick Allen, RPh
Georgia Drugs and Narcotics Agency

Allen Butts, MD
The Longstreet Clinic

Cecil Cordle, PharmD
CVS Pharmacy, Tifton

Rafael Pascual, MD
Northeast Georgia Medical Center

Prepared by the Senate Research Office
2016

TABLE OF CONTENTS

COMMITTEE FOCUS, CREATION, AND DUTIES

The Senate Study Committee on Opioid Abuse (Committee) was created with the adoption of Senate Resolution 1165 during the 2016 Legislative Session. The Committee was charged with undertaking a study of opioid abuse and issues surrounding the rise in overdose deaths involving opioids.

The following individuals were appointed by the President of the Senate to serve as members of this Committee:

- Senator Renee Unterman of the 45th, Chair
- Senator Butch Miller of the 49th
- Commissioner Brenda Fitzgerald, Department of Public Health
- Rick Allen, RPh, Georgia Drugs and Narcotics Agency
- Dr. Allen Butts, The Longstreet Clinic
- Cecil Cordle, PharmD, CVS Pharmacy, Tifton
- Dr. Rafael Pascual, Northeast Georgia Medical Center

The following legislative staff members were assigned to this Committee: Jared Evans and Elton Davis of the Senate Budget & Evaluation Office; Ines Owens of the Senate Press Office; Elizabeth Holcomb and Koko Lewis of the Senate Research Office; Lynn Whitten of the Office of Legislative Counsel; and Avi'el Bland, Senate Health and Human Services Committee Secretary and Legislative Assistant to Senator Unterman.

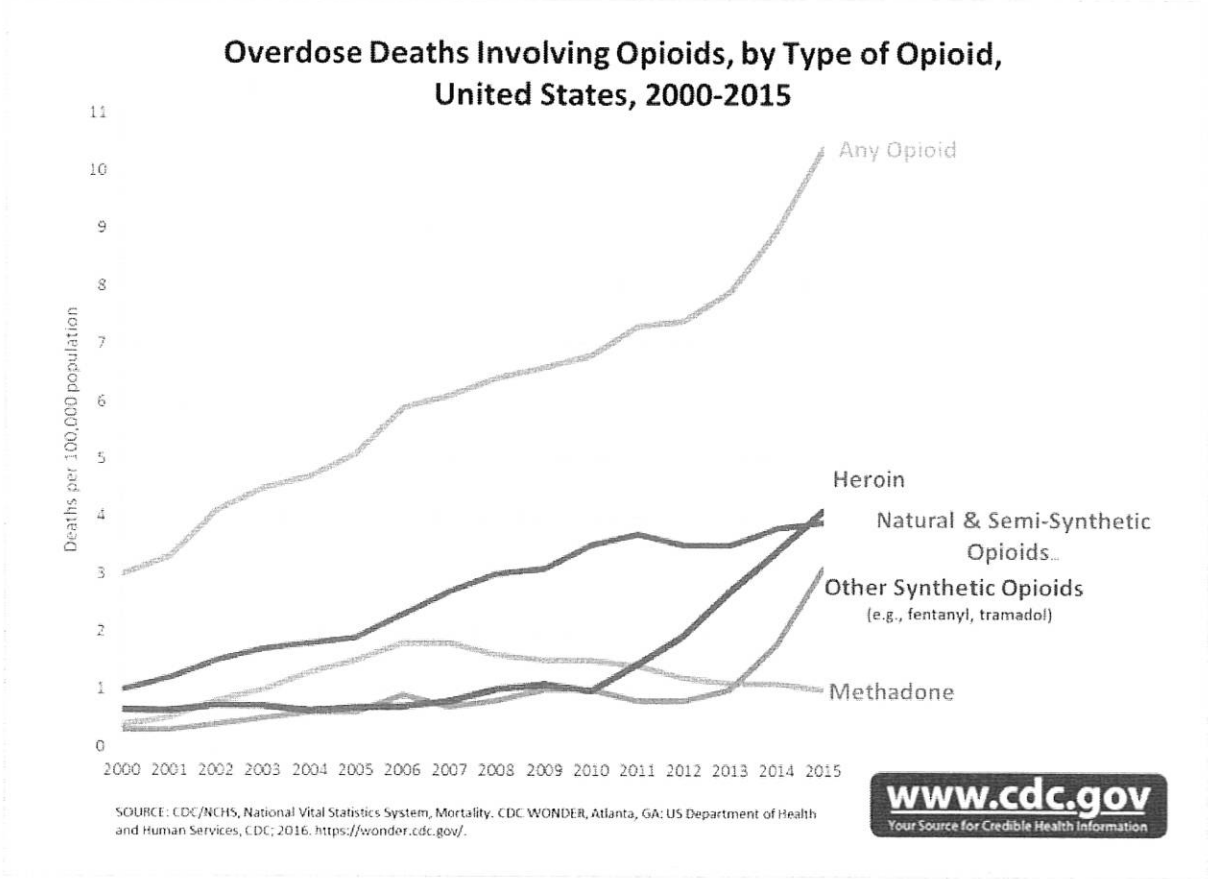
BACKGROUND

The Opioid Epidemic

According to the Centers for Disease Control and Prevention (CDC), two distinct but interconnected trends are driving America's opioid overdose epidemic: (1) a 15-year increase in deaths from prescription opioid overdoses; and (2) a recent surge in illicit opioid overdoses driven mainly by heroin and illegally-made fentanyl.

The CDC's National Center for Health Statistics found that the number of overdose deaths involving opioids rose from 28,647 in 2014 to 33,091 in 2015. This figure and the data below on the number of deaths involving opioids in 2015 were released in December of 2016.

- Heroin overdose deaths rose from 10,574 in 2014 to 12,990 in 2015, an increase of 23 percent.
- Overdose deaths involving synthetic opioids other than methadone rose from 5,544 in 2014 to 9,580 in 2015, an increase of 73 percent. This category of opioids is dominated by fentanyl-related overdoses, and recent research indicates the fentanyl involved in these deaths is illicitly manufactured, not from medications containing fentanyl.
- Taken together, 19,885 Americans lost their lives in 2015 to deaths involving primarily illicit opioids: heroin, synthetic opioids other than methadone (e.g., fentanyl), or a mixture of the two.
- Overdose deaths involving prescription opioids, excluding the category predominated by illicit fentanyl, rose only slightly from 16,941 in 2014 to 17,536 in 2015, a 4 percent increase.



The figure above shows the rise of overdose deaths involving all opioids as well as four categories of opioids considered by the CDC. These categories of opioids are outlined below and were referred to throughout the Committee's study.

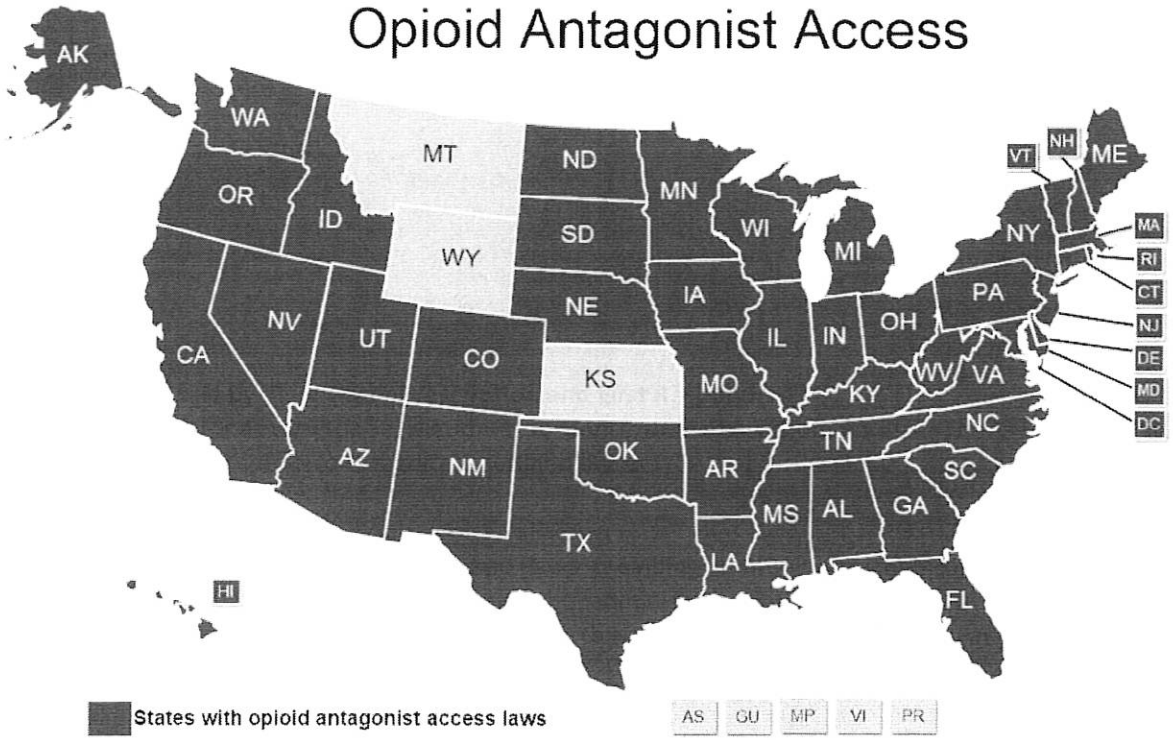
- **Natural opioid analgesics,** including morphine and codeine, and **semi-synthetic opioid analgesics,** including drugs such as oxycodone, hydrocodone, hydromorphone, and oxymorphone;
- **Methadone,** a synthetic opioid;
- **Synthetic opioid analgesics** other than methadone, including drugs such as tramadol and fentanyl; and
- **Heroin,** an illicit (illegally-made) opioid synthesized from morphine that can be a white or brown powder, or a black sticky substance.

Access to Naloxone by Third Party Prescription and First Responders

Almost every state has enacted legislation in response to increased opioid use. The laws passed by a majority of states fall into two categories, outlined below.

Laws Providing Access to Opioid Antagonist Naloxone

As of August 2016, 47 states have passed laws providing immunity to medical professionals who prescribe or dispense naloxone or persons who administer naloxone. Previously, laws required a doctor-patient relationship to be established prior to issuing a direct prescription to an at-risk drug user and third party prescriptions were prohibited.[1]

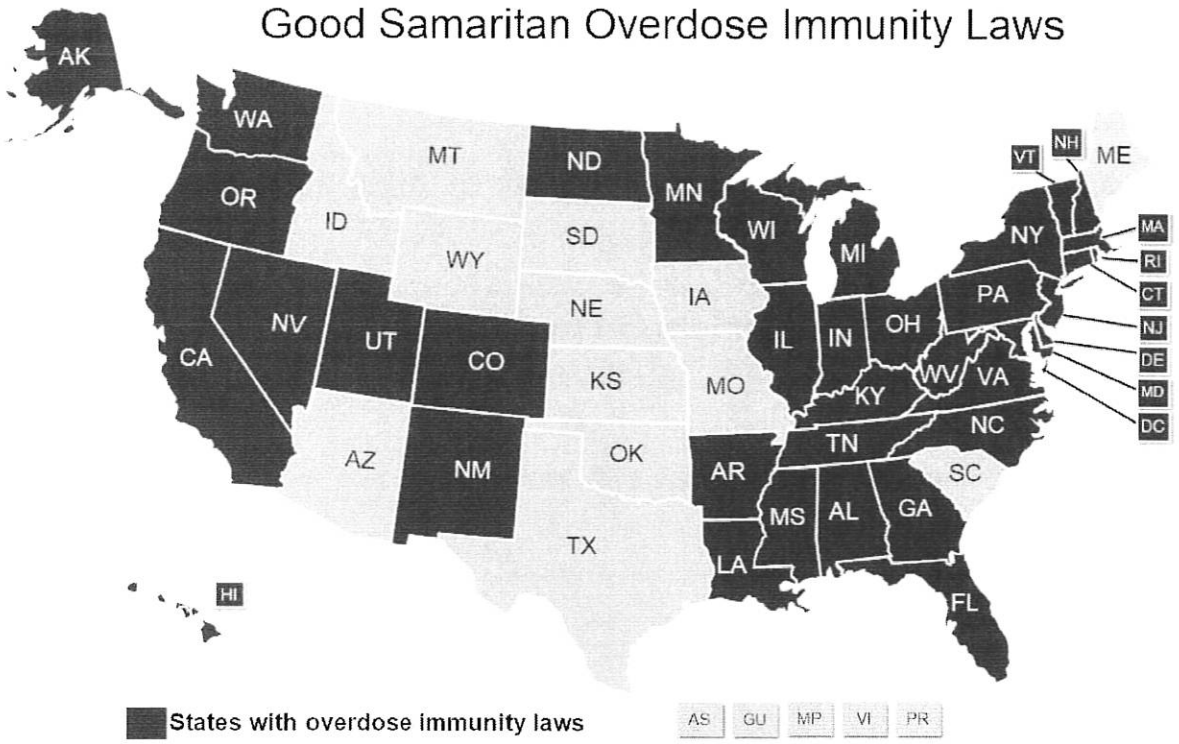


Source: NCSL, 2016

Good Samaritan Laws

The figure below shows that 37 states and the District of Columbia have enacted some form of a Good Samaritan or 9-1-1 drug immunity law to encourage people to seek medical attention for a drug overdose. In general, these laws provide immunity from supervision violations and low level drug possession and use offenses when a person seeks medical attention for himself/herself or another for a drug overdose. Immunity is extended to persons who have a reasonable belief that someone is experiencing an overdose emergency and makes a report of such belief in good faith.

[1] A third-party prescription is an order written for medication dispensed to one person with the intention that it will be administered to another person.



Source: NCSL, 2016

As you can see from the figures above, many states have laws addressing both categories and Georgia's law has been in effect since 2014 with the passage of House Bill 965. This bill was introduced as the Georgia 9-1-1 Medical Amnesty Law by Representative Sharon Cooper and reached final passage with the language of House Bill 966 through a committee substitute passed by the Senate Health and Human Services Committee. Specifically, the law authorizes practitioners to prescribe opioid antagonists to certain individuals and entities pursuant to a protocol, allowing pharmacists to dispense and opioid antagonist pursuant to a physician's prescription. Such prescriptions may be made by a physician to a third party individual or entity for another person at risk of experiencing an opioid related overdose, to be used by the third party under physician's protocol. Third party individuals and entities include: a pain management clinic, first responder, harm reduction organization, family member, friend, or other person in the position to assist the person at risk of overdosing. The law also authorizes first responders, EMS personnel, and paramedics to carry and administer opioid antagonists pursuant to a licensed physician's order.

Naloxone Access and Over-the-Counter Sale Barriers

The interest in laws that allow individuals to bypass a doctor's office and obtain naloxone from pharmacies has increased in 2016 after Walgreens and CVS began selling naloxone. Although a variety of sources and individuals describe this type of access as OTC, this is technically incorrect since naloxone is a prescription-only drug that has not been designated by the FDA for OTC sale. Still, other states have employed a variety of approaches to allow individuals to access naloxone at a pharmacy without first seeing a prescriber and getting a traditional prescription. The primary objective of this study committee was to gain a better understanding of these approaches and identify a model approach for Georgia.

MEETING TESTIMONY

This section provides a brief summary of topics covered at each meeting, including the names and affiliations of individuals who were asked to provide testimony to the Committee. Although testimony has been condensed to ensure the report could be timely submitted, copies of all presentations and materials submitted to the Committee are kept on file in the Senate Research Office.

Meeting 1 – September 30, 2016

The first meeting was held at Northeast Georgia Medical Center in Gainesville, Georgia, and consisted of an overview of the issues related to opioid abuse. The individuals who provided testimony and the titles of each presentation are listed below.

- "Opioid Drug Abuse Today – Trends and Implications in Georgia"
  - Kay Hall, MBA, RN, Northeast Georgia Medical Center
- "Opiates: The New Epidemic"
  - Joni B. Powell, CACH, Support Services Supervisory, Laurelwood
  - Trisha Ziem, MACL, LPC, Assessment Coordinator , Laurelwood
- "Opiates: Neonatal Abstinence Syndrome"
  - Brittany Smith, RN, MSNEd, Unit Manager, Neonatal Intensive Care Unit, Northeast Georgia Medical Center
- "Advantages and Disadvantages of Narcan Sold Over the Counter"
  - Melissa Frank, Director of Pharmacy, Northeast Georgia Medical Center

Meeting 2 – October 17, 2016

Meeting 2 was held on October 27th at the Capitol and continued the discussions from the previous meeting on neonatal abstinence syndrome, prescription drug policies for pain medications, and efforts to prevent substance abuse. The Committee expanded the scope of this study to include the ramifications of addiction and examine how neonatal abstinence syndrome impacts social services and Georgia's foster care system. The following individuals provided testimony:

- Tom Fitzgerald, MD, Emergency Medicine, Tanner Medical Center
- Jane E. Ellis, MD, PhD, Associate Professor of Maternal-Fetal Medicine, Medical Director, Emory Regional Perinatal Center; Grady Memorial Hospital; Vice Chair, Georgia Maternal Mortality Review Committee
- Paul Browne, MD, Section Chief, Associate Professor of Maternal Fetal Medicine, Augusta University
- Karen Dudley, MD, Neonatalogist, Northside Hospital
- Trish Witcher, RN, MSN, Labor and Delivery Unit Nurse, Northside Hospital
- Lee Biggar and Andy Kogerma: Georgia Department of Family and Children Services (DFCS)
- Jim Langford, Georgia Prevention Project

In addition to providing oral testimony, Mr. Langford distributed a summary of a white paper by the Substance Abuse Research Alliance (SARA). A final copy of SARA's "Prescription Opioids and Heroin Epidemic in Georgia" was distributed to the Committee shortly after the December meeting and is provided in Exhibit A of the Appendix.

Meeting 3 – November 9, 2016

The Committee held a third hearing on November 9th at the Capitol. Testimony was provided to the Committee by the following individuals:

- John Horn, U.S. Attorney, Heroin Working Group
- Lt. William Ricker, Zone 1 Crime Suppression Unit Commander, Atlanta Police Department
- Sarah B. Flack, Director of the Community Prosecution Unit for the Atlanta Judicial Circuit
- Kathleen O'Connor, Public Policy and Regulatory Affairs, Shatterproof
- Dr. Michael Fishman, Director of Young Adult Program at Talbott Recovery Atlanta;
- Laurisa Barthen, Outreach and Communications Coordinator, Georgia Council on Substance Abuse;
- Jim Langford, Georgia Prevention Project

Meeting 4 – December 13, 2016

The Committee returned to the Capitol for a fourth meeting on December 13, 2016. Testimony was provided by the following individuals:

- Cassandra Price—Director of the Office of Addictive Diseases at DBHDD
- Virginia Pryor—Deputy Director of Child Welfare at DFCS within DHS
- Brook Etherington—Vice President of the Opioid Treatment Providers of Georgia; CEO of Alliance Recovery Center

After hearing testimony, Mr. Allen provided an update on Georgia's PDMP to his fellow Committee members.

COMMITTEE FINDINGS

Access to Naloxone

The Committee was created to increase access to naloxone in Georgia by identifying a legislative mechanism to allow pharmacists to independently dispense naloxone to an individual without a physician's prescription. At Meeting 4, Senators Renee Unterman and Butch Miller shared background information on this topic with the Committee, which was previously provided to them by the Senate Research Office. The Georgia Retail Association submitted written materials to the Committee but did not provide oral testimony.

Other states have employed a variety of approaches to bypass the need for a physician to issue a prescription, including: collaborate practice agreements (CPAs), pharmacist-as-prescriber models, and standing order legislation.

1. Legislation allowing **collaborative practice agreements (CPAs)**: where a practitioner delegates medication management authority to a pharmacist, where the pharmacist can prescribe the drug and offer front-line medical advice to the purchaser;
2. Legislation for a **Pharmacist-as-Prescriber** model: allowing pharmacists to furnish medication to a patient without the involvement of a physician;
3. **Standing Order** Legislation: which allows for the dispensing of naloxone under standing orders, where prescribers are given the authority to prescribe the medication via such an order, and are granted limited immunity with regard to such prescriptions so long as they act in good faith.

At Meeting 4, Commissioner Fitzgerald and Mr. Allen agreed that a standing order would be feasible in Georgia. The next day, the Board of Pharmacy adopted Emergency Rule 480-34-0.31-.11 (Naloxone) to allow pharmacists to dispense naloxone to individuals pursuant to a statewide standing order issued by Commissioner Fitzgerald. According to the rule, the steady and sharp increase in the number of overdoses and deaths due to prescription and illegal forms of opioid drugs poses an imminent threat to the public health, safety, and welfare; and naloxone is critical in assisting persons at risk of overdose.

Synthetic Opioids

The Committee heard testimony from law enforcement officials on the dangers of handling fentanyl and carfentanil in the field at Meeting 3. On September 22, 2016, the DEA issued a warning to the public and law enforcement regarding the dangers of carfentanil, a drug linked to a significant number of overdose deaths in the nation.[2] Carfentanil is a synthetic opioid analgesic that is 10,000 times more potent than morphine and 100 times more potent than fentanyl, which itself is 50 times more potent than heroin.

Law enforcement officers told the Committee that access to more than one dose of naloxone is extremely important in overdose cases involving fentanyl or carfentanil.

[2] https://www.dea.gov/divisions/hq/2016/hq092216.shtml

Georgia's Prescription Drug Monitoring Program

Georgia's Prescription Drug Monitoring Program (PDMP) was established in 2011 to assist in the reduction of the abuse of controlled substances; to improve, enhance, and encourage a better quality of healthcare by promoting the proper use of medications to treat pain and terminal illness; and to reduce duplicative prescribing and overprescribing of controlled substances practices. The Georgia Drugs and Narcotics Agency maintains the PDMP through a program known as PMPAware. All Georgia licensed Dispensers (pharmacies and dispensing prescribers) are required to submit information for dispensed Schedule II, III, IV and V controlled substance prescriptions to PMPAware on a weekly basis.

Under Georgia's PDMP law, only physicians owning or practicing in pain management clinics are required to query the PDMP before prescribing any Schedule II through IV Controlled Substance. Additionally, only physicians owning or practicing in pain management clinics are required to register with the PDMP. As Ms. O'Connor of Shatterproof explained at Meeting 3, Georgia law allows access to information for review or investigation but it does not require the PDMP to proactively analyze and distribute data in cases where high-risk behavior is most probable.

Mr. Allen provided a detailed report and update on Georgia's PDMP, which is available in Appendix C. The Committee agreed that physicians would have a greater incentive to participate in the PDMP if the system was updated more often. The cost to upgrade the system to update every 24 hours was estimated to be between $20,000 to $30,000 per year.

Neonatal Abstinence Syndrome

The Committee heard testimony at Meetings 1 and 2 on the prevalence of neonatal abstinence syndrome (NAS) in the U.S., where a baby is born with NAS every 25 seconds. Testimony at Northeast Georgia Medical Center provided the Committee with detailed information on the various symptoms associated with NAS. The medical costs associated with each child born with NAS are estimated at roughly $93,400, and the long-term effects of NAS may include learning disabilities and delayed motor skills. Dr. Karen Dudley, a neonatologist at Northside Hospital, emphasized the importance of a system-wide approach and home intervention to the Committee. Additionally, Northside has a "Quality Improvement Initiative" that uses a protocol-based approach that has led to a decreased average stay for infants born with NAS.

The Department of Family and Children Services (DFCS) provided testimony at Meeting 2 on how increased opioid abuse has affected the delivery of social services in recent years. According to DFCS, cases involving opioid abuse or other drug addiction can be very challenging for caseworkers who already face high volume caseloads.

The Committee also heard testimony on the best practices for treating addiction in pregnant women, including detox programs that use methadone as a treatment approach. Dr. Paul Browne, an associate professor of maternal fetal medicine at GRU, provided testimony on Augusta University's addiction program for pregnant mothers. Dr. Ellis of Augusta University told the Committee that the best strategy in achieving neonatal and fetal outcomes is to make sure the mother's needs are met, which may include appointment reminders and transportation to treatment sites. While there is no detox program at Northside, Dr.Dudley believes that having the conversation about NAS with parents beforehand is very helpful.

Heroin Working Groups

Additional testimony was provided by prosecutors and law enforcement officers who have first-hand knowledge and experience with the opioid crisis in Georgia. As Mr. Horn described at Meeting 3, Georgia is part of the opioid crisis but has not reached a catastrophic point like some states (e.g. West Virginia and Ohio). The Fulton County Heroin Working Group discussed at Meeting 3 was modeled after programs in Pittsburgh, Pennsylvania and Cleveland, Ohio. The Committee was encouraged to hear testimony on the effectiveness of the heroin working groups in Georgia and the opportunity to expand these efforts in other areas of the state.

Prescription Drug Policies in Emergency Departments

As Ms. Hall explained at Meeting 1, the Emergency Department (ED) is the largest source for opioid analgesics and is estimated by the National Center for Health Statistics to generate roughly 39 percent of all opioids prescribed in the U.S. Unlike other vital signs, pain is subjective and more difficult to assess since it cannot be proven through a medical test. ED physicians are faced with the burden of carefully assessing each patient presenting with pain while also achieving high patient satisfaction scores regardless of whether a prescription for pain medication is issued. Concerns over whether the push for patient satisfaction contributes to provider prescribing habits are significant, leading some EDs to implement a prescription drug policy. Northeast Georgia Medical Center (NGMC)'s ED Controlled Substance Policy was approved in 2012 and consists of a uniform policy that educates patients on adherence to the policy and redirects patients to community resources for the management of chronic pain, which should occur by one non-emergency provider. Dr. Tom Fitzgerald provided testimony at Meeting 2 on the development of a similar policy by Tanner Medical's ED.

Medication Assisted Treatment Sites for Opioid Addiction

Brooke Etherington, Vice President of the Opioid Treatment Providers of Georgia, provided testimony at Meeting 4 on how Medication Assisted Treatment Sites (MATs) in Georgia vary by facility size and services. This variance explains why those who work in the MAT industry tend to shy away from calling these facilities "methadone clinics." Committee members expressed concerns regarding certain facilities that reportedly dispense methadone like a vending machine and made several references to "pill mills." According to Mr. Etherington, all MATs in Georgia should be regulated and subject to inspections.

Approaches to Address Substance Abuse in Georgia

Jim Langford of the Georgia Prevention Project distributed a summary of a white paper by the Substance Abuse Research Alliance (SARA), which was later finalized in December 2016. In addition to the SARA white paper, Mr. Langford provided testimony on outreach prevention and education programs.

COMMITTEE RECOMMENDATIONS

Based on the foregoing findings, the Committee makes the following recommendations:

- Legislation should be introduced in 2017 to codify the effect of Emergency Rule 480-34-0.31-.11 (Naloxone) that was adopted by the Georgia Board of Pharmacy on December 14, 2016. This rule increases access to naloxone to individuals by allowing pharmacists to independently dispense naloxone in cases where a patient-specific prescription has not been issued by a physician. The Committee agrees that O.C.G.A. § 24-6-116.2 should be amended to authorize the State Health Officer (Commissioner Brenda Fitzgerald) to issue a statewide "standing order," which would function as a prescription for opioid antagonists/naloxone for any persons or entities she chooses to name in the order.
- The Committee agrees that first responders need additional funding sources for naloxone, especially with the increased use of synthetic opioids that often require more than one dose to achieve an effective reversal. Funding for naloxone should be increased to ensure first responders are equipped with adequate supplies.
- The Committee supports efforts to improve the utility of Georgia's Prescription Drug Monitoring Program by: mandating reporting by all prescribing physicians; increasing funding to expand the ability of GDNA to review and make data available; and developing an application that will allow the system to update its information every 24 hours. An exception to physician reporting requirements should be considered for prescriptions of five pills or less, which would decrease workload related to minor procedures or some acute pain treatments. Additionally, continuing medical education should be developed for physicians and other prescribers on narcotics, proper prescribing, and the use of alternative medications. Narcotic prescriptions should be tracked by DEA and anyone writing over a decided number should be looked at to verify legitimacy of practice.
- The Committee agrees that medication assisted treatment sites (MATs) should be regulated in Georgia and intends to share its findings with the Commission on Narcotic Treatment Programs to formulate a legislative solution to this issue.
- The progress of the heroin working groups should be closely monitored in hopes that a statewide model can be developed in the future.
- The Committee recommends a continuance of state funds for DBHDD to support addiction treatment and recovery services. Additional funding resources should be explored to support early intervention efforts and coordination with DFCS for children born to drug addicted mothers.
- There should be a consistent approach to chronic pain management across our health systems in Georgia. The Committee supports bringing experts together in a future study to develop a uniform system that can implemented on a state level.
- Finally, Georgia needs to be proactive in its effort to address the opioid epidemic and explore funding opportunities to ramp up outreach prevention and education programs on school campuses.

CONCCURING REPORT BY DR. RAFAEL PASCUAL

Regarding the PDMP and mandating prescriber participation:

Participation should not be required if prescriber writes for a prescription duration of under 7 days. Additionally, the PDMP website should be updated for ease of use and allow physician assistants, techs or nurses be allowed to access site for the physician.

Respectfully Submitted,

FINAL REPORT OF THE OPIOID ABUSE SENATE STUDY COMMITTEE

Renée S. Unterman

Honorable Renee Unterman, Chair
Senator, District 45

Wilmington's Solution to the Opioid Crisis

A coastal North Carolina city ranks first in the nation in opioid abuse. Now it wants to become an innovation hub for battling the crisis.

BY: J. Brian Charles | September 1, 2017

Jonathan Alexander Hayes was driving while high on opioids. It was the morning of Nov. 1, 2016, and the 24-year-old was approaching the busy intersection of Oleander Drive and Independence Boulevard in Wilmington, N.C., when he overdosed.

Ahead of Hayes' truck was the Richardson family. Mason, who was three days shy of his third birthday, was riding with his mother and four-year-old brother when Hayes rear-ended their car.

Hayes' truck was traveling so fast that it kept going, striking another car before finally coming to a stop roughly 100 yards down the street, according to the Wilmington Police Department.

Two-year-old Mason was killed in the collision.

Emergency personnel at the scene revived Hayes with a dose of the drug naloxone, which is administered to reverse the effects of an opioid overdose. It, was by some estimates, the fourth time Hayes had received the drug in less than six months.

For the city of Wilmington, the incident was a wake-up call -- one that will make it an incubator for addressing the opioid epidemic. "The flashpoint was the death of Mason," says Mayor Bill Saffo.

Wilmington Responds

Wilmington, which sits along the southern swath of North Carolina's coast and whose Antebellum homes and beautiful beaches attract thousands of tourists each year, is now the nation's capital for opioid abuse, according to a study by Castlight, a health-care information company. More than 1 in 10 Wilmington residents who received an opioid prescription abuses the drug.

The spike in opioid addiction and overdoses caught Wilmington flat-footed back in 2012. "I don't know why," says Saffo, "but we got hit pretty damn hard down here."

Between 2014 to 2016, opioid overdose deaths more than doubled from 24 to 53 -- and those, says Saffo, "are just the deaths we know about."

Crime also increased. "We started to notice the presence of heroin on the street and the drug gangs [were] becoming more active," says Mitch Cunningham, deputy police chief. "The number of shots fired was up, as were aggravated assaults."

After Mason's death, city officials began to rethink their approach. "We asked ourselves, 'Do we need to take a step back and look at what is the best way to handle [opioid abuse]?'" says Tony McEwen, assistant to the city manager for legislative affairs.

Saffo formed a task force made up of law enforcement, medical professionals and politicians to address Wilmington's opioid crisis. The group started its work in January and by early spring settled on a three-part plan.

Under the first part of the plan, Wilmington emergency responders will continue to carry naloxone. The drug was first deployed in the city in March 2016, and since then it has saved 87 lives and been administered more than 100 times.

But opioid users were being revived only to return immediately to using, says Cunningham. It was a revolving door. So, as part of the plan, a "rapid response team" of medical and social work professionals will visit a user

within 72 hours of receiving naloxone. They will ask, not coerce or force, the user to enter treatment. If he or she refuses, the team will make additional visits until the person agrees to get help.

The rapid response team is modeled after a program in Colerain Township, Ohio, a suburb of Cincinnati. Like in Wilmington, officials there saw a spike in opioid addictions and overdoses. Initial numbers from its rapid response program have been promising. Colerain flaunched its rapid response program in 2015, and in the first year reported a 40 percent reduction in overdoses and a 74 percent success rate in getting addicts into treatment.

Wilmington will also hire health-care navigators, says McEwen. Many of those addicted to opioids lack health care and are often not capable of wading through the reams of paperwork necessary to connect them with treatment options.

The price tag for the rapid response team in Wilmington is $500,000 over two years. Another $500,000 will pay for the healthcare navigators. Wilmington will implement the program once it gets the funding from the state, which city officials expect to receive in the next 90 days.

Finally, the third part of the plan is already under way. In June, Wilmington launched the Law Enforcement Assisted Diversion program, which instead of arresting people for possession allows officers to divert them to treatment. "Instead of criminalizing someone with an addiction issue, we are giving law enforcement the discretion to get them to more appropriate services," says Olivia Herndon, director of continuing education, mental health and public health at the South East Area Health Education Center in Wilmington.

Not a Partisan Issue

Opioid addiction is a national crisis. But no region has been as hard hit as the South. Of the 25 cities which have recorded the highest rate of opioid abuse, 22 are in the South. Four of those cities are in North Carolina.

In June, *The Washington Post* reported that the volume of deaths from the opioid crisis was reminiscent of the crack epidemic of the 1980s. Back then, the federal government responded with the War on Drugs, which favored a tough on crime approach. As a result, incarceration rates skyrocketed. It was seen largely as a failure.

So this time around, law enforcement and state and local leaders are taking a different approach. They are viewing the opioid crisis as a public health problem. In other words, law enforcement is in many ways decriminalizing addiction and working with public health professionals "From a law enforcement perspective," Herndon says, "they are saying they cannot arrest their way out of this."

In June, North Carolina Gov. Roy Cooper signed the Stop Opioid Misuse Prevention Act. The law prohibits doctors from prescribing more than a five-day supply of opioids on an initial visit. Health-care providers are required to register their prescriptions electronically with the state to prevent "doctor shopping," where patients shop around for physicians who will give them access to opioids.

The bill was a bipartisan effort, as was appropriating funding for Wilmington's plan to address its opioid crisis. In an era of partisan gridlock, such cooperation is rare, especially in North Carolina. But the politics on opioids seem not to matter, says Saffo. "For the statehouse to give us this money so quickly speaks to how important this issue is to everyone across the country. What I have found in this whole debate is that it's hitting every community in this state, urban and rural, and it's hitting every strata, rich and poor."

Wilmington will report its findings from its programs to the state in hopes that what city leaders learn there can be applied statewide and nationwide "It had been said that Wilmington was an epicenter for this problem," says McEwen, "and we want to be an innovation hub for it."